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## ORIGINAL COMMUNICATIONS.

ARTICLE I.—*Laryngotomy, after Apparent Death—Recovery.* By GEO. AMERMAN, M.D., late House Surgeon of Bellevue Hospital.

Mary Smith, aged 25, widow, born in Canada; parents both living, and in good health. During her residence in Canada she enjoyed uniform good health, except having had those diseases incident to childhood, and one or two attacks of intermittent fever. At the age of fifteen she was married; one year after she was delivered of her first child, which was perfectly healthy and is still living. Two years after her first confinement, she gave birth to her second child, which was, also, at the time of birth in good health, but died four months after with some affection of the bowels. She then left her husband and removed to the city of New York. Two years after her arrival she contracted primary syphilis, which was cured in six weeks. One year afterwards she began to suffer from secondary symptoms—sore throat and eyes. Two years ago she gave birth to her third and last child, which, unlike the two preceding, was sickly and puny, and died at the age of thirteen months. Three months ago the difficulty of the throat greatly increased, and she was also attacked with rupia. She applied to a physician, but, owing to the exposure she was obliged to

undergo, she failed to obtain relief, and was admitted into Bellevue Hospital, April 10th, 1856. At the time of her admission, she had large bullæ over the whole upper part of the body and head. The throat was not carefully examined; and I am unable to say whether or not it was ulcerated. She had no dyspnœa or pain; her pulse was good, but her condition indicated an impaired constitution and a general syphilitic cachexia. She was ordered small doses of hyd. bi-chlo., with the tinct. cinch. co., good diet, and anodynes at night. About five hours after my visit, I was hastily summoned to her by the nurse, who told me she was dying. I found her sitting up in bed, unable to speak and gasping for breath; her lips and ends of her fingers were livid, and the veins of the neck distended. The dyspnœa was so severe that it seemed to threaten immediate suffocation. On examining the throat, nothing was perceptible, except a general redness of the fauces, which was most intense on the anterior surface of the epiglottis. Pressure over the larynx caused some pain. Inspiration was more difficult than expiration. Physical examination of the chest revealed nothing abnormal. The air entered the lungs and was resonant throughout. It was thought expedient to try scarifications, which, however, proved useless. An emetic of zinci sulphas was next given, but without producing emesis. Her dyspnœa had now become so alarmingly urgent, that it was decided to open the air passages. Laryngotomy was the operation proposed, as the obstruction was thought to exist in the larynx—probably at the vocal cords. Some time necessarily elapsed in preparing the instruments, &c., prior to the operation; and, just as I was about to make the first incision, the patient gave a gasp, and apparently expired. All respiration, or efforts to respire, ceased. The pulse, which had been before extremely feeble and rapid, now became more so; and, in half a minute after she ceased to breathe, her heart stopped pulsating. At the moment respiration ceased, I proceeded rapidly with the operation, and in one and a half minutes succeeded in introducing the tube. Artificial respiration was resorted to, and in less than a minute (between one-half and one minute) natural respiration commenced. I think there was

an absence of the respiration for at least two minutes, and of the pulse for at least one and a half minutes. The respiration ceased first and was first restored. When the patient was fully resuscitated, her pulse, though feeble, was regular and much slower, her respiration perfectly easy, and she sank into a quiet and refreshing sleep. Some trachitis followed the operation; but her recovery was as rapid as could have been expected. She wore the tube for twelve days, when it was removed and the wound allowed to close. Her rupia was treated with alternative doses of hyd. bi-chlo. and tinct. cinch. co.; but it seemed to have very little good effect, and, instead, large doses of iod. potassa were substituted, which acted promptly and beneficially. The large scabs became detached, and slowly separated, leaving a healthy ulcer underneath, which rapidly healed. Her recovery was complete. The wound in the throat closed, and respiration through the natural passages became free and easy.

## REMARKS.

During my residence in Bellevue Hospital, laryngotomy was performed four times for syphilitic disease of the throat, and in all the cases the operation was successful. Two of them left the Institution entirely cured. In both, the tube was worn for a shorter time than one month, when they were able to breathe easily through the natural passages, all symptoms of disease of the throat having disappeared. The third case died, eight months after the operation, from lupus, which had extended to the base of the scull and excited secondary arachnitis, which was the immediate cause of death. In this case the tube was never removed. The fourth case was the one whose history I have given above. It was perfectly successful. The tube was worn for twelve days, when all signs of disease in the throat disappeared. This case is also interesting in two other particulars:—*First*, As showing the necessity of the operation; and, *Secondly*, the complete relief afforded by it. So far as these cases go, they point to the conclusion already arrived at by some surgeons, that, in cases of acute disease supervening on chronic syphilitic affections of the throat, the obstruction is situated in the larynx, and that laryngotomy affords relief, and

hence, being an easier operation than tracheotomy, should be performed.

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**ARTICLE II.—*Injury of the Knee-Joint—Inflammation—Amputation—Recovery.*** Treated by Dr. H. A. JOHNSON, one of the Physicians to the Mercy Hospital. Reported by P. J. Wardner.

Michael White, a native of Ireland, aged 44 years, was admitted, May 30th, with necrosis of the tibia, and severe inflammation in and about the knee-joint, which proceeded from an injury received in November last while laboring on the railroad. At the time of the injury he felt no immediate effects of a serious character, but in the month of January he fell, in passing out of the house, and gave it a severe sprain, which confined him to the bed, with much pain and swelling in the soft parts about the upper third of the tibia and outer condyle of the femur; for which he was treated by a German doctor up to the time of his admission. What his treatment had been we were unable to learn, but, when admitted, he had a severe cough, constipation of the bowels, was much reduced, and had a blister on both sides of the knee-joint. He was put upon such internal treatment as his condition required, with a view to allay the cough and regulate the bowels, after which he took tonics and alteratives, varied as circumstances required, with local applications to the part affected.

This treatment was continued up to about the 1st of July, at which time the cavity of the joint, and tissues surrounding and above it, were infiltrated with pus. The swelling began to extend up the thigh, and his general health to suffer very materially. On the 10th of July, the patient having been placed upon the operating table, Dr. Johnson made the following remarks to the students in attendance:—

“*Gentlemen*—The questions that naturally arise, are, first, as to the propriety of making any further efforts to save the limb; secondly, as to the propriety of the amputation of the femur. In reference to the first, the disease has progressed steadily and uniformly, so far as we can learn, from its commencement to the present time, notwithstanding the use of all



those means which are generally followed by success in similar cases. The general condition of the patient has been such as to require constant treatment, and he is now rapidly failing. These considerations lead me to think, that it is not only useless, but that the life of the "patient will be endangered by any further efforts to save the limb. While we wish to be regarded as an advocate of conservative surgery, we do not feel justified in deferring an operation when there seems to us, as in the present instance, to be a greater probability of the death of the patient without it, than the cure of the diseased member. In reference to the propriety of an operation in this case, the only question that remains to be asked, is, Does the history of the case, and the present condition of the patient, warrant us in the presumption that he will survive the operation and be ultimately restored to health? The probabilities are in his favor, therefore we shall proceed to operate."

The femur was amputated at the junction of the middle and lower third, the patient being placed under the influence of chloroform; after which he was put upon such remedies as were intended to repair the lost energies of his system. Nearly the whole extent of the cut surface united by the first intention. The ligature came away on the seventh day, and he was dismissed on the 7th of August with a perfect stump, and in good health.

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ARTICLE III.—*Poisoning by Strychnine—Case of Wm. Palmer.* By J. C. MORFETT, M.D., Chicago.

The evidence in the celebrated case of William Palmer, tried and convicted of poisoning John Parsons Cook with Strychnine, is of so much interest, both in a medico-legal point of view and on account of the high position of the medical witnesses, that we will give a synopsis of it.

Mr. Cook was a sporting gentleman, of Rugely, England, intimate with Palmer, and was to have received £2,000 on Monday, Nov. 19th, 1855, in consequence of his horse having won a race, Nov. 13th. On Wednesday, Nov. 14th, the day after the races, Palmer and Cook were drinking brandy and water. After drinking part of a glass, Cook said, "There's

something in it, it burns my throat. Palmer took up the glass and, drinking the balance, said, "There's nothing in it." Cook, after that, was seized with such violent vomiting that he was obliged to go to bed, but was relieved in the night. The next day Cook went to the races. On Friday, 16th, he dined with Palmer, and went to bed that night perfectly well. On Saturday, 17th, at an early hour, Palmer came to Cook at the "Talbot Arms," and ordered coffee for him. Palmer gave Cook the coffee, and, immediately after taking it, the same symptoms set in which had occurred to him on Wednesday. He continued sick all of that and the next day. On Monday, Palmer, who had been much of the time with Cook, left for London, and immediately Cook began to improve—sat up for several hours, and was altogether much better. Palmer returned to Rugely that same night, Monday 19th, at 9 o'clock, and at once visited Cook at the "Talbot Arms," and from that time until 10 or 11 o'clock was continually in and out of Cook's room. In the course of the evening he went to an apothecary, and bought three grains of strychnine. Mr. Bamford, the medical attendant, had that day sent to Cook some pills, such as he had previously prescribed, containing half a grain of calomel, half a grain of morphine, and four grains rhubarb. Palmer generally came in to administer the medicine. There is no doubt Cook took pills on Monday night: when Palmer left Cook that night, he was very comfortable, but, at 11, the servants of the house were alarmed by cries from Cook's room, and they found him in great agony and intense pain, shouting murder. *He was flinging his arms wildly about, and his whole body was convulsed. He was perfectly conscious,* and desired Palmer to be sent for. Palmer came directly and administered some medicine to Cook, which he vomited almost immediately. Shortly he became more calm, and called upon the servants to rub his limbs. He gradually fell into repose, and began to dose.

The next morning, Tuesday 20th, Cook was comparatively comfortable, and he was ordered to take pills at bedtime. These pills were made by Mr. Bamford, at his surgery, but were given to Palmer to administer to Cook. The latter vom-

ited as soon as he took them. That night he was attacked as before, screaming violently, gasping for breath; his body convulsed with cramps and spasms, and his neck rigid. Cook asked Palmer for the same medicine which had relieved him before, and Palmer brought two pills, which he told the medical attendant were of ammonia. The sick man swallowed these pills, but brought them up immediately. He was instantly seized with violent convulsions; by degrees his body began to stiffen out, then suffocation commenced. He entreated to be raised, but his body was "stiff as iron," and it could not be done. He then said, Pray turn me over," and they did turn him over, when he gasped for breath and in a few moments died. Previously Cook had suffered from syphilis, but had been cured for some time.

At the coroner's inquest, Mr. Bamford, the medical attendant, testified that he died of apoplexy. At the post mortem examination, which took place Nov. 26th, six days after death, the body was found stiff and the hands clenched. The abdominal viscera and brain were quite healthy, and normal in every respect; the heart was contracted, and contained no blood; the blood was in a fluid state; the spinal cord was not minutely examined, but found, as far as examined, in a healthy state; the stomach was opened its whole length, and with its contents and the intestines put in again for analysis. On the 25th January, two months after death, the body was examined again, and with the same result, except that on the spinal cord were found certain granules. This, Dr. Monckton said, he had frequently seen in old people, but was not sufficient to account for the symptoms.

Mr. B. Curling, who was examined, testified that he was familiar with tetanus, having written a work on the subject, and did not think the symptoms of Cook referable to that disease, as the sudden onset of the symptoms and their rapid subsidence are not consistent with either of its two forms, viz., idiopathic or traumatic.

Sir. B. Brodie, judging from the symptoms which accompanied Mr. Cook's death, was of opinion that, so far as there was a general contraction of the muscles, they resembled those

of traumatic tetanus; but, as to the course these symptoms took, they were entirely different. He did not think death, in this case, arose from what is ordinarily called tetanus, either idiopathic or traumatic; neither were they the result of apoplexy or epilepsy.

Mr. Solly's testimony was substantially the same.

Dr. Alfred S. Taylor testified as follows:—I made a careful analysis of the stomach and intestines, without finding any trace of strychnia. I found antimony in the liver, one kidney, and spleen. I gave it as my opinion that he had died from the administration of that substance, because I was told that he had been taken suddenly ill, and died in convulsions. I did not then know his symptoms, but now think they were referable to strychnine. I have made experiments with rabbits; and, in two instances where strychnine was administered, have been unable to detect it after death. The symptoms of poisoning by strychnine are nearly uniform. In about five or six minutes, when the poison begins to act, there is a trembling, quivering motion of the whole muscles of the body; there is then a sudden paroxysm or fit, the fore-legs and hind-legs are stretched out, the head and tail are drawn back in the form of a bow, jaws spasmodically closed, and eyes prominent. After a short time there is a slight remission of the symptoms, and the animal appears to lie quiet, but the slightest noise or touch produces another paroxysm. Sometimes there is a sort of shriek as if the animal suffered pain; the heart beats violently after a fit, and, after a succession of fits, the animal dies quietly. Sometimes the animal dies during a paroxysm, and I only know that death has occurred, from holding my hand over the heart. The appearances after death differ: In some instances, rigidity continues; in one case the muscles were so strongly contracted for a week that it was possible to hold the body out horizontally by the hind-legs; in some instances I found congestion of the membranes of the spinal cord, but in others there was no departure from the ordinary state of spinal cord and brain: in all cases the heart has been congested, especially the right side. I believe the symptoms in Cook's case to have been produced by strychnine. Strychnine is absorbed, and

where only a small quantity has been given at a time, and it has been carried into the circulation, it is impossible to discover it in the tissues.

Dr. G. G. Rees assisted Dr. Taylor in the analysis, and coincided with him entirely in the testimony.

Dr. Christison had also been unable to detect strychnia in the dead body of animals poisoned with it; and agreed with Dr. Taylor that it was sometimes impossible to detect it.

Dr. Thomas Nunnely deposed, that he had always found traces of Strychnia in the body in various stages of decomposition. It could not be absorbed without its presence being detected in the tissues or blood. No amount of putrefaction, within ordinary limits, will prevent the discovery of it—he had found it at the end of forty days. The sudden accession of the symptoms, screaming, vomiting; power to talk, swallow, and move freely, led him to believe that this was not a case of death from that poison. He never knew an animal to scream voluntarily after having taken strychnine. When there is so much spasm of the heart, there must be inability to vomit. He thought Cook's symptoms due to great excitement. In poisoning by strychnine, the rigor mortis is not greater than in death from other causes.

Mr. William Herapath testified, that in all cases in which strychnine had been given, he had been able to find it after death. He has found it in the blood, heart, and urine, besides the stomach. He could detect the fifty-thousandth part of a grain, if unmixed with organic matter.

Dr. Henry Letheby has witnessed many cases of animals poisoned with strychnine, and does not think the symptoms accorded with those attending the death of Cook. Strychnine is the most easily detected of all poisons; never failed to find it when it had been administered; always found the right side of the heart full.

Dr. Ungletson, a pupil of Liebig, testified that he has discovered strychnine in the tissues, urine, blood, and viscera. He administered half a grain to a cat, and detected it in the urine. If a man were poisoned with strychnine, he would expect to find it in the stomach within five or six days—should

be confident of finding it even when administered in minute quantities. If a long interval had elapsed, would expect to find it in the liver, spleen, and kidneys.

The evidence in this case was so voluminous, that we have only given an abstract of it on some particular points. It will be seen that there was a conflict of opinion among some of the most eminent medical men who were brought as witnesses; and it was to give the views of these that we undertook this abstract. Those who wish to read the testimony in full, will find it in the *London Lancet*, for July, 1856.

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ARTICLE IV.—*Singular Effect of a Blow on the Occiput.*

By the EDITOR.

Mr. F., a native of Ireland, aged about 22 years, previously in good health, while sitting on his sewing bench at work as a tailor, received a severe blow with a press-board directly on the most prominent part of the occiput.

The blow was sufficient to lacerate the scalp and produce temporary unconsciousness. From the latter he soon recovered, and, after having the wound dressed by a surgeon, he was carried to his lodgings.

The following day, June 8th, I was called to see him. I found the wound looking well, and the patient without any symptom of disease or injury, except a slight acceleration of pulse and heat of skin, with total inability to swallow either fluids or solids. If the patient made a strong effort to swallow, the liquid would no sooner reach the pharynx than it was forcibly ejected through the mouth or nostrils, or both, accompanied by severe spasmodic action of the diaphragm and great distress in the epigastrium. Finding no evidence of either fracture of the skull or compression of the brain, I simply directed cold applications to the occiput, the bowels to be moved by an enema of salt and water, and entire quietude.

The next day, I found the patient in precisely the same condition, except that the slight febrile symptoms had disappeared; the bowels had moved well, and the patient felt well, except the entire inability to swallow a drop of anything, and the spasmodic action of the diaphragm and respiratory muscles conse-



quent upon every attempt to do so. I directed a continuance of the cold cloths to the head, and a blister to the back of the neck.

*June 11th.*—The blister drew well, but produced no change in the symptoms. The patient, when at rest, feels perfectly well, except a sense of oppression or tightness around the lower part of the chest; the skin is cool; pulse 70 per minute, soft and natural; the wound in the scalp nearly healed, and entirely destitute of inflammation. The inability to swallow was still complete, although the efforts to do so were accompanied by less spasmodic action of the diaphragm, and less distress than at first. To afford the patient some support, and, at the same time, produce some change in the condition of the nervous system, I directed a teacupful of beef-tea, containing ten drops of tinct. opii, and the twelfth of a grain of strychnine to be introduced into the rectum, each morning, noon, and night. These were continued daily, the whole being retained until completely absorbed, and they afforded the patient so much nourishment that very little emaciation ensued, although the patient remained without swallowing a drop until the 22d, fifteen days after the injury.

From the 16th to the 22d there was a gradual change: the spasmodic action which was so distressing to the patient at first, whenever an attempt was made to swallow, entirely ceased, and liquids would pass at least two inches down the œsophagus, where they would be invariably arrested and forced back. After causing the patient to make a faithful, but unsuccessful, attempt to swallow both liquids and solids, on the 22d I passed an elastic stomach tube through the œsophagus into the stomach; through it I introduced half a pint of cold water, there being neither beef-tea nor milk at hand, though I had asked them to have both ready: the tube was then withdrawn. In passing it, there seemed to be a very slight resistance about midway between the pharynx and the cardiac orifice of the stomach. It gave the patient no pain, and at no time had there been any soreness of the throat. In a few hours after the stomach tube was withdrawn, the patient succeeded in swallowing, and in a few days entirely recovered.

ARTICLE V.—*Medical Knowledge.* By J. R. FREESE, M.D., of Bloomington, Ill.

From the days of Hippocrates, down almost to the present, Medical knowledge has been confined to the few, while the great mass of mankind have neither sought or cared to know anything concerning it.

Twenty years ago, the idea of having physiology taught in our common schools would have been thought preposterous; and even the leading colleges of our country, while they were careful to teach their classes Xenophon's *Anabasis* and *Memorabilia*, Demosthenes de Corona, *Evidences of Christianity*, *Natural Philosophy*, Aristotle's *Art of Poetry*, *Geology*, *Zoology*, &c., yet they never once thought it important to add the study of ONE'S SELF; as though to *know ourselves* were of but little importance in comparison with knowing the "dead languages," and sciences, from which we could never hope to reap any practical advantage!

I, for one, am exceedingly glad that a change is beginning to take place on this all-important subject; that the first principles of our noble science are beginning to be disseminated among the people; that our common schools have introduced the study of physiology, and our literary colleges made it a part of their studies; that well-informed physicians have thought it no disgrace to our profession, and no breach of medical ethics to lecture to the people on physiology and hygienic law; that physicians, instead of holding themselves aloof from the people, as though they were part and parcel of a separate creation, are beginning to mix with the people and converse with them in such a plain yet scientific manner as to enlighten, instead of be-fogging the minds of their patrons. To me these signs are propitious, and I hail them with great joy.

I am also well pleased to notice a greater amount of sociability among the members of our own profession; and a disposition not only to permit and urge on the spread of true medical knowledge among the people, but a free interchange of sentiment, to spread knowledge among ourselves. Dr. Palmer, of Chicago, in his report on the "Organization of

State and County Societies," made to the American Medical Association, at its recent meeting at Detroit, has done the profession a great service; and, if his plan is adopted and carried out, not only will the members of the profession be benefited, but the people of every State and County, in which such an organization may be effected, will be correspondingly benefited.

In proportion to the amount of medical knowledge among the people, will be the respect and honor paid to the well-informed physician. Quackery can only flourish among the ignorant—and the greater the ignorance, the greater the quackery. A competent physician has no need of cloaks or seals to his profession. He knows his business, and if he is so fortunate as to have a set of patrons who understand something of the human system, of the laws of health, and the power of medicines, he will grow up among them to be loved, honored, and cherished for his knowledge of head, and goodness of heart.

Of course I admit, that the *amount* of medical knowledge necessary to make a competent physician and surgeon, must always be confined to the few, comparatively, because there are only a few that will go through the long study, and spend the amount of time and money, necessary to such an end: yet, in admitting this, it lessens not my hope and my strong desire that true medical knowledge will continue to spread among the people; that it will continue to be made a part of common school and collegiate education; that the professors of our medical colleges, and especially our medical journals, will mingle more with, and be scattered more among the people—teaching them a knowledge of themselves, and the means whereby to prevent and to cure the many ills to which human flesh is heir to.

I look forward to the effects of such a spreading of medical knowledge as a kind of medical millenium; and, having strong faith in its steady and rapid approach, I hope, myself, to live long enough to see it and enjoy a share of its professional blessings.

ARTICLE VI.—*Case Bronchitis—Pleurisy, with Effusion—Pneumothorax—Death.* By RALPH N. ISHAM, M. D., Chicago, Ill.

James Marr, aged 40, married, a native of Ireland, by occupation a stone-dresser, was first seen by me Jan. 15th, 1856.

No hereditary tendency to disease traceable; both of his parents died at an advanced age of life.

The patient, a muscular, well-developed man, of medium stature, states that "he has never been ill a day in his life," until his present attack. Is not a temperate man, and at times indulges *freely* in intoxicating drinks.

Ten days previous to my first visit, (Jan. 5th,) after exposure to wet, he was siezed with "shiverings of cold," lasting some hours, and followed by a sharp pain in the left side, aggravated by deep inspirations. He states that he was bled freely from both arms, and blistered by his medical attendant, who, for some unknown reason, abandoned his case.

*Present Condition.*—He complains of pain in the left side, a severe and harassing cough, accompanied with a viscid, frothy, white expectoration, showing no blood under the microscope, and which has been present from the commencement of the disease; skin hot and dry; pulse full, soft, and accelerated; tongue coated with a greasy white fur, edges red; bowels regular; appetite poor; insomnia.

*Physical Signs.*—Left side, posteriorly, from inferior angle of scapula to the base of the lung, dulness on percussion; over a space, bounded by the dulness superiorly and inferiorly, and extending three inches from the spine, is heard bronchial respiration, but none heard over the left auxiliary and lateral regions; increased vocal resonance over space above bounded. Sibilant and sonorous rales heard over the whole chest. Ordered C.C., (dry,) xij., to each chest, and ipecac., with Dover's powder every third hour.

*Jan. 17.*—Pleuritic effusion in left chest has taken place; ordered diuretics and flying blisters. Feels much improved, pain in the chest absent, and considerable moisture of surface.

*19th.*—Has grown gradually weaker; fluid increased; considerable dyspnœa; profuse perspiration; tongue still coated,

and no appetite. Moderate stimulus added to treatment, with generous diet.

23d.—Dyspnœa increasing. Œdema of feet and ankles first noticed; no œdema of chest. Tongue coated, pulse rapid and feeble. The fluid has reached the middle of dorsum of scapula. The heart's apex beats at junction of fifth rib and sternum—left side. Bronchial respiration is heard over a space one inch square, at level of fluid, and about four inches from the spine. Sonorent and sibilant rales diminished, but not entirely absent.

23d, *Vespere*.—Patient suffers from orthopnœa; the countenance is anxious and of a dusky hue; pain on percussion of left chest, amphoric respiration, and metallic voice, and cough heard on left side. No metallic tinkling; no resonance on percussion; no change in the expectoration.

Considerably relieved by the use of proper remedies.

28th.—Physical signs the same, with the heart further displaced; apex pushed to the right side, having, as it were, swung upon its axis. Tympanitic percussion in front of left chest.

The patient had refused to submit to the operation of thoracentesis, being somewhat relieved by the use of proper remedies; but, on the 7th of February, he became suddenly worse, and died.

Duration of illness, 33 days.

*Sectio Cadaverous—20 hours Post Mortem.*—A trocar introduced into the left chest, between the eighth and ninth ribs, posteriorly, (erect posture,) gave exit to pus, in amount 40 ℥. The lung was found pushed up to the anterior superior portion of chest, adherent to the front and side, but not behind. A small strip of lung extended posteriorly nearly to the diaphragm, and was adherent to that muscle by a dense band of false membrane. The remainder of the chest was filled with pus and air.

The blowpipe, introduced into the trachea, inflated both lungs tolerably well, but failed to detect the point of perforation. The trachea was then dissected up, and the blow-pipe introduced into the left bronchus, when bubbles of air arose through the water placed over the lung, showing the perforation

which had taken place at the point where the bronchial respiration had been so persistent during life. The opening was valvular, and concealed by false membrane. No tubercles existed in either lung. Heart natural; liver large and fatty; kidneys slightly granular, and weighing  $8\frac{1}{4}$  oz. each.

The occurrence of bronchial respiration in pleuritic effusion, is not a rare phenomenon, and, as is illustrated by this history, may occur in *recent* as well as in chronic cases. In two examples recorded by Dr. Graves, the usual signs of effusion were well marked, and, being of an urgent nature, paracentesis would have been performed but for the presence of this bronchial respiration, which was heard over the anterior portion of chest in a line drawn vertically through the mammary region, and also posteriorly above and below the scapula. On dissection of these cases, which was similar in both, "a strong adhesion extended from two inches below the clavicle of the affected side in a line passing through the middle of the mammary region, nearly to the bottom of the anterior part of the lung." "This adhesion, about two inches in breadth, was very firm and close, so as to form an intimate union between the pulmonary substance and the anterior parieties of the chest, and extended nearly from the apex of the lung to its base. Along this line the pulmonary tissue formed a plate of compressed lung, two inches in thickness, which, like a vertical partition, divided the pleural cavity into two chambers, each filled with sero-purulent matter, and separated by the lungs, extending from its root to its anterior adhesions."\*

Its presence in these cases, as well as the one under consideration, may, perhaps, be partially accounted for by the entrance of air into the larger bronchial tubes, which were not obliterated; but, why it is so often absent, is still unexplained, and can only be solved by careful observation.

The absence of rales, the displacement of the heart, and the bulging of the intercostal spaces, are the signs upon which we are chiefly to rely in distinguishing the bronchial respiration of pleurisy from that of pneumonia. In the resolution of the lat-

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\* Dublin Hospital Reports, Vol. V.



ter, its disappearance is accompanied by the rales crepitans redux, which are of course absent in pleurisy.

This case, furthermore, shows, that the obliteration of the intercostal spaces is not necessarily present in cases of emphysema even when the heart is displaced and the lung much compressed. And from the fact that it does not occur in pneumonia; that in emphysema it is accompanied with resonance on percussion; and that in simple pneumothorax, although the action of air upon the pleura gives rise to rapid effusion, supplanting the resonance by dulness, it may be distinguished by Hippocratic succussion whether the perforation is closed or not, renders this a valuable sign where present. Its absence in this case tends to establish the correctness of Dr. Stokes' opinion, that it is caused by paralysis of the intercostal muscles, produced by inflammation of the pleura; for effusion to a great extent was undoubtedly present, accompanied with eccentric pressure, necessarily great on account of the valvular arrangement of the perforation, which, whilst it readily admitted the air in the chest, prevented its easy egress.

On reviewing this case, no question as to the perfect propriety of paracentesis can be raised, had the patient consented, occurring, as it did, in a good subject, without tuberculosis, and a fluid of a purulent character.

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## SELECTIONS.

### *On the Alkaline Method of Treatment in Acute Rheumatism.*

By JAMES GRAHAM, M.D., Prof. of Materia Medica and Therapeutics, in the Medical College of Ohio.

Dr. John H. Griscom, one of the Physicians to the New York Hospital, has recently presented to the profession the results of his experience in the treatment of acute rheumatism by the alkaline method, and these results correspond so closely with my own at the City Infirmary, during my late connection with that Institution, that I venture to offer a few general remarks on the subject.

Dr. Griscom's statistics comprise twenty-six cases, and the

average time that his patients were under treatment was about thirteen days; the duration of the whole attack averaging about twenty-one days. Dr. G. asserts, that under the most improved plans of treatment heretofore pursued, the average duration of treatment has been about six weeks. There is one point to which this physician particularly alludes, in which his experience is strongly corroborated by my own, viz., the freedom from cardiac and other complications which attended the alkaline treatment. In not a single instance did such complication manifest itself after the patient's admission into the Hospital, and the testimony of the other physicians of the Institution establishes the same fortunate exemption.

I was first led to try the alkaline method by the perusal of Dr. Henry William Fuller's most excellent work on rheumatism. Dr. Fuller, as many are aware, maintains that in acute rheumatism the blood is contaminated by a poison, "which is at once the source and maintainance of the mischief;" and he further asserts, (p. 73,) that this *materies morbi* is an acid, or an acidulous compound, which can be eliminated only by a free exhibition of alkalies and neutral salts. He admits, however, that purgatives, sudorifics, and diuretics, by promoting the various excretions, may assist in accomplishing the object, yet alkalies are essential to prevent the further formation, and to effect the elimination of the morbid element. The remedy preferred by Dr. F., is the potassio tartrate of soda, which is readily decomposed in the stomach, acts quite as energetically, and is much better tolerated than corresponding quantities of the alkaline carbonates. Dr. F. made some experiments to determine the efficacy of impregnating the joints affected with alkaline matter, and though these were not sufficiently extensive to enable him to form a positive opinion, yet, on the whole, they "proved extremely satisfactory." The most serious complication of acute rheumatism, it is needless to add, is heart disease. The frequency with which this occurs, may be inferred from the statistics collected by Dr. Fuller, during the period he held the office of medical registrar at St. George's Hospital, London, viz., from the 1st of January, 1845, to the 1st of May, 1848. Of 379 cases observed by him, embracing all the examples of acute and sub-acute rheumatism admitted, the heart was healthy in 160 instances, in 32 *probably* healthy, while in 187 it was temporarily or permanently deranged to a greater or less extent. These statistics certainly present a most formidable aspect, as some form of disease existed in about half the cases. Now, to preserve the heart from mischief, according to Dr. Fuller, it is necessary not only to take pre-

cautions against inflammation, but to maintain the solubility of the fibrin of the blood, and, for this purpose, I am satisfied we must rely on the free administration of alkalies and the neutral salts—the experience of Dr. Fuller, Dr. Griscom, as well as my own, having satisfactorily shown that they surpass all other agents in preventing fibrinous deposits on the valves. Dr. Griscom administered the sup. tart. pot. et soda. in drachm doses, every hour, and ordered an anodyne lotion of carb. potas. and tinct. opii to be applied to the joints affected. Alteratives and evacuants preceded the employment of these remedies, according to the indications presented. The severity of the symptoms was found to diminish as the urine became less acid.

I am aware that Dr. Roderick Macleod, who, at the time of the publication of his work on rheumatism, (1842,) was also physician to St. George's Hospital, has given the results of his experience in the treatment of rheumatism, based on 400 cases attended by him in his public capacity, and that he claims in favor of the blood-letting and purging treatment the average duration attained by Drs. Fuller, Griscom, or myself. For example, of 266 cases, 148 were discharged cured within a month, 110 within a fortnight, and 60 within eight days. Dr. Hope asserted, that under a similar method of treatment, in his practice, the cases were exceptional which were not cured within a week. Dr. Corrigan, with large and repeated doses of opium, cured his cases in nine days. Bouillaud, by copious and repeated abstraction of blood, required from one to two weeks for the same purpose, and yet, if report be true, he lost six out of eighteen patients from cardiac disease.

But I have extended my remarks beyond the limits which I proposed. My only object, in offering a few observations on the alkaline method of treatment, is to bear my humble testimony in its favor, fully believing, as I do, that it is capable of effecting a more speedy and perfect cure than any other plan that has ever been adopted. To those who are skeptical on the subject, I would recommend the study of the facts collected in Dr. Fuller's treatise. In this a comparative view may be taken, which, in my opinion, must satisfy every unprejudiced mind. It will there be found, that the boasted success of the authors whom we have mentioned, admits of considerable qualification, and is in reality less than has been asserted.—*Western Lancet.*

*Ununited Fractures. Stated Meeting, New York Academy of Medicine, July 2, 1856. The President, Dr. W. PARKER, in the Chair.*

The discussion of the subject of Ununited Fractures being in order, it was opened by

Dr. Detmold, who stated the cause of non-union to be both local and constitutional; but sometimes no cause could be assigned. The old method of causing union, was, to excite inflammation between the fractured extremities, by friction, blisters, the seton, &c. Resection and wiring the ends together, was another mode. Dr. D. stated that Dr. Mott's cases (where the seton had been employed) were only successful where it had been necessary to *drill*, in order to introduce the seton; and he thinks that Dr. Mott was misled in this way. Dieffenbach resorted to drilling and fastening with ivory pegs. Five years ago Dr. D. had tried boring with a common gimlet, and was successful in all cases. A Committee from the Academy had seen one of these operations. This method was afterwards claimed by a Western surgeon (Dr. Brainard).

Dr. Buck referred to the local conditions preventing union, such as portions of muscle or tendon getting between the ends of the bone. Dr. B. gave the history of a case in which union of the humerus was prevented in this manner. In the tibia and fibula it is sometimes almost impossible to keep the upper fragment of the tibia in place, and the union of the fibula often kept up this difficulty. Dr. B. spoke of Malgaigne's apparatus for overcoming this displacement. He had both failed and succeeded with both seton and exsection. The perforating method was generally successful in about twelve weeks. Friction was useful where the cases were not of too long standing.

Dr. Detmold stated that he had been successful with the perforating method, where Dr. Buck had failed with the seton. He had also been very successful with a fractured ulna, after the third trial. One great advantage of the perforating method, was, that it leaves no unpleasant symptoms. He had often operated at his office, and allowed the patient to go home. Another advantage was, that it could be repeated any number of times; another, that it does not shorten the limb. He had never failed in the operation. He repeats the operation in one week, if no union has taken place.

Dr. Buck stated that he introduced the seton in a case, by means of perforating, and union followed; but, afterwards, it was again broken, and the patient came under the treatment of Dr. Detmold.

Dr. Parker considered this question important for all practi-

tioners, as it often occurred when no cause could be assigned for it, when there was no fault on the part of the surgeon, and was often the basis of mal-practice suits. In non-union of the lower extremities of hospital patients he used the starch bandage, recommended all possible use of the limb, together with good diet, fresh air, and stimulating drinks. *Excision* (as introduced by White, of Edinburgh, in 1760, and improved by J. K. Rodgers, of this city, by wiring the ends together,) was often successfully employed. *Electricity* is useful; he knew of one case treated successfully by this agent. Dr. P. had noticed that operations on the upper extremities were followed with less success than on the lower, and asked for an explanation of this. He had been successful with the drill; and asked if any benefit was derived from leaving the chips or borings in the hole—he he thought there might be.

Dr. Detmold agreed with Dr. Parker that these bony particles, or debris, served as a nucleus for the new union.

Dr. Stone thought that in these cases of fracture it was especially important to ascertain whether the case was one of *delayed union*, or one of *true false-joint*, where the bones were covered with cartilage, and where a new synovial capsule existed. In the upper extremity, particularly in the humerus, false joints were not uncommonly found, and the fractured extremities, if oblique, could not be readily approximated. In such cases he did not believe the operation by the gimlet, as proposed by Dr. Detmold, would be likely to succeed, or that any operation promised success unless it had for its objects the removal of the cartilage and destruction of the capsule, and the approximation of the broken extremities to each other. In the lower extremities, especially in fractures of the tibia, it was extremely rare to meet with cases of false joint. He (Dr. Stone) had never met with a single instance, and was disposed to regard them rather as cases of *delayed union*, which would readily unite if a very little inflammation could be excited. Dr. Stone would expect to obtain this result by the repeated application of blisters; others, by rubbing of the bones together; but, Dr. Detmold, by boring with a gimlet. This suggestion of Dr. Detmold was a useful one; but in the fact of union taking place in a week, it proved that very little inflammation was necessary. Dr. Stone had been on the Committee who investigated Dr. Detmold's cases, and had then come to this conclusion. As to the idea that the dust or debris contributed to the union, he must confess that it seemed to him to be truly fanciful; he should suppose that the dust must necessarily be removed in abstracting the gimlet; or, on the supposition that

it might possibly be left behind, he should regard this as an untoward accident, which would be likely to act as a foreign body and produce abscesses.

Dr. R. S. Kissam remarked that he was successful in one case of non-union of the humerus, by means of the starched bandage.

Dr. Batchelder remarked that fractures are solutions of continuity in the bones, which heal in the same way as do like solutions of continuity (wounds) in the soft parts, *i. e.*, by the first or second intention. When the fractured extremities in simple fractures are brought and kept in apposition, the lacerated vessels, pertinent to the bone in the immediate vicinity of the fracture, inosculate, and union by the first intention ensues, as in wounds in the soft parts; with this exception, that the earthy matter which immediately surrounds these vessels at the place of fracture must be first absorbed. This preliminary step is accomplished in a longer or shorter time, according to the age of the patient, or size of the bone. When the crepitus ceases to be perceived, it is an indication that the absorption of the earthy matter is nearly or quite completed; and as motion at the place of fracture diminishes, we infer that re-union is progressing about in proportion to the diminution of abnormal motion; so, when this motion has ceased, the inference is that union has taken place, and that the process of re-deposition of ossific matter among and around the vessels has begun, or will soon begin, and continue till callus is completely formed, provided the fractured parts are kept in position and motionless. If such motion be allowed, the newly-formed vascular union will be broken up, and the re-union will be prevented, and the process have to be gone over with again. When the parts are much disturbed and the union repeatedly broken up, the vessels, thus foiled in their attempts to repair the injury, refuse to renew their efforts, but, uniting with the periosteum, form a ligamentous union, which, while it serves as a connecting medium between the ends of the bone, keeps them asunder, and prevents bony union. To get rid of this interposed ligamentous substance, and cause absorption of the earthy matter surrounding the vessels in the immediate vicinity of the fracture, is the first object which surgery should aim at as essential to the cure. In the larger bones this ligamentous union is very conspicuous, and is most perfect in cases of ununited fracture of the neck of the femur. In these cases, the capsular ligament is folded in between the fractured surfaces, and acts in the first instance as an extraneous body which tends to prevent osseous union, but which in the end



contributes mainly to that which is ligamentous. The objects to be aimed at in all our endeavors to cure ununited fracture, are:—1. To get rid of this interposed ligamentous substance; 2. To promote or effect the absorption of the earthy matter which surrounds the vessels at the broken ends of the bone; 3. When this is accomplished, to bring and keep these ends in apposition, that the vessels thus prepared may inosculate and unite as they should do, and probably would have done in the first instance if they had had fair play, or if there had been no fault in the patient's constitution. The method which Dr. B. has adopted and practiced, (with few exceptions in favor of the starch dressing,) is, to wind a bandage firmly around the affected limb, in order to prevent swelling below the part to which the appropriate application is to be made. This done, a piece of thick sole-leather, soaked in water until perfectly soft and pliable, cut and fitted exactly to the limb, and long enough to reach from joint to joint, and sufficiently large to cover the whole, is to be applied and bound firmly on with a bandage. While this dressing is being consolidated, great care must be taken to put and keep the fractured extremities in perfect apposition, or as nearly so as possible; which is best accomplished, when the lower extremity is the affected member, by relays of assistants, who will hold the parts *in situ*. When this dressing has become dry and consolidated, measures should be taken to make the lower fragment press firmly against the upper. As nothing in the system can resist pressure, and as newly-formed parts yield readily to its influence, the interposed ligamentous substance, of which we have spoken, and also the earthy matter immediately surrounding the vessels at the fractured ends, are soon absorbed, and the vessels which have been thus freed of osseous matter will unite, and the union be re-established. In case of a lower extremity, it may be proper to let the patient get up and move about with the help of crutches, and, perhaps, bear more or less weight upon the foot, taking care to do it in such a way as to cause as little motion between the fractured ends as possible; especially after a short time; as motion, if kept up, would infallibly prevent union. If it be the humerus, the patient should be confined to his bed, and an apparatus, besides the rubber-splint, be so contrived and applied as draw the lower fragment up, and force the fractured surfaces to press firmly one against the other, which cannot be so well done in the erect or sitting posture as in the recumbent. This bone (the humerus) is the one in which the artificial joint most frequently occurs, and in which the usual methods of cure have most signally failed. In reflecting upon

these facts, it has occurred to Dr. B. that both these accidents were to be imputed to our mode of treating these fractures; splints are firmly bandaged on, which, with the weight of the limb below the fracture, prevent the muscles drawing the lower fragment up, and causing it to make the requisite pressure against the fractured end of the upper portion—in which opinion he has been fully confirmed, when finding at the end of several weeks there was no union: the impending evil has been immediately obviated by applying an apparatus which caused the fractured ends to press one against the other. He believes that this method of treatment will effect a cure in most cases of ununited humeri, even of long standing.

In compound fractures, union takes place by the second intention, which does not usually commence, or is not appreciated, until the external wound is nearly or quite closed. Dr. B. remarked that the starch bandage, the gutta percha splint, and probably the gypsum bandage, as recommended by Dr. Mathysen, (which he had never tried,) will no doubt be found better than the leather splint, which was resorted to many years before anything was known of even the starch bandage, or the "dextrine," as recommended by Prof. Van Buren.

Dr. Batchelder exhibited a specimen from Dr. Finnell's collection, of ununited fracture of the radius and ulna, which beautifully illustrated the manner in which the ligamentous union is formed.

Dr. Finnell remarked, that the man to whom the ulna and radius, referred to by Dr. Batchelder, belonged, had good use of his arm. In St. Vincent's Hospital he had often found it necessary to use stimulants freely. He approved of electricity.

Dr. Phelps observed that all present must conclude, that the main point in practice was to secure a certain amount of inflammation in the ends of the bone before union could be produced.

Dr. W. Parker said, that the question seemed brought to two points:—1. Where there is no union by ligament; and, 2. Where there is a false joint. So long as the inflammation is mild, there is no union. Again, there is such a thing as too much inflammation. Diarrhoea, lactation, burns, suppuration, &c., may prevent union. A physician of this city who had a fracture and an injury of the brain, was severely salivated, and no union took place until the salivation ceased, at the end of thirteen weeks. The system must be brought to the ordinary standing point, by correcting it if deranged, and bringing it to a proper tone. But, in a false joint, an operation must be performed.

Dr. McNulty presented an instrument for the purpose of

introducing a platinum wire between the ends of an ununited bone, by means of which he proposed to pass a galvanic current to act as a cautery, and thus produce inflammation and union. Dr. McN. was requested to give the history of the cases in which he might try it.

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## BOOK NOTICES.

*Physical Exploration and Diagnosis of Diseases Affecting the Respiratory Organs.* By AUSTIN FLINT, M.D., Professor of the Theory and Practice of Medicine, in the University of Louisville, &c. Philadelphia, Blanchard & Lea, 1856.

This volume has been on our table for several months, waiting a notice—waiting not from want of merit in itself, but for want of time on our part to give it such an examination and review as it deserves. This time we have not yet found, and we bespeak the indulgence of both author and publishers.

Dr. Flint is one of the most industrious and energetic men in the medical profession of this country. His previous contributions to our medical literature, have won for him both American and European reputation, and we assure our readers that the present volume is full of valuable and interesting matter. The work is divided into two parts: the first of which treats of Physical Exploration of the Chest; the second, of Diseases Affecting the Respiratory Organs. We present the following summary of the sounds heard on percussion, both for the purpose of showing the doctrines of the author, and for their intrinsic value:—

### SUMMARY.

“The abnormal sounds developed by percussion are distinguished from each other, and from the normal thoracic resonance, by variations in timbre, or quality, in intensity, in pitch, and in duration. For practical purposes it suffices to arrange them into divisions based on differences in intensity and in quality; variations in pitch and duration furnishing incidental characters. Thus arranged, the several classes of abnormal sounds are as follows: 1, exaggerated vesicular resonance; 2, diminished resonance; 3, absence of resonance; 4, tympanitic resonance.”

1. Exaggerated vesicular resonance is characteristic of vesicular emphysema. It is highly distinctive of that affection, unless the distension of the cells and expansion of the thoracic walls be very great, when the sonorousness may be diminished. Exaggerated resonance from emphysema retains the vesicular quality distinctive of normal resonance, but this quality may be diminished more or less, and the sound approximate in timbre to the tympanitic. In proportion as the latter alteration takes place, the pitch is raised."

"2. Diminished resonance, or dullness, occurs, as a general rule, when a thin stratum of liquid removes the lung a short distance from the chest; when the pulmonary substance is condensed by pressure of liquid effusion within the pleural sac, or, more rarely, by fluids in the bronchial tubes, by serous effusion within the cells or areolar tissue, and by vascular engorgement; by tumors encroaching on the thoracic space, and by deposit of solid products within the lungs, viz., coagulable lymph, tubercle, carcinomatous matter and a bloody clot; *cæteris paribus*, the degree of dullness is in proportion to the extent to which the air-cells are compromised, and the relative quantity of air to the solid parts reduced. Important exceptions to this rule are observed. In a large proportion of cases of pleural effusion, the percussion-sound above the level of the liquid, for a variable period during the progress of the disease, is exaggerated, and in its character tympanitic. The same is true of the percussion-sound over the healthy lobe on the side in which the lower lobe is solidified in pneumonitis. A tympanitic resonance is propagated from the stomach and intestines in cases of solidification of the lower lobes, more especially the left lobe. It accompanies also, sometimes, partial solidification from tubercle, or other deposits at the summit of the chest. Whenever the sound becomes dull, the pitch is raised, and the duration shortened. The pitch is also higher when it becomes tympanitic. The diseases in which diminished resonance occurs, with the exceptions just stated, are pleurisy and hydrothorax, above the level of the liquid; pneumonitis; oedema of the lungs; great congestion; pulmonary apoplexy; carcinoma, and tuberculosis."

"3. Absence of resonance, or flatness, is occasioned by an accumulation of liquid in the pleural sac, and exists below the level of the liquid; sometimes by complete solidification in pneumonitis, and by tumors, or morbid growths. An increased sense of resistance, under these circumstances, is marked."

"4. Tympanitic resonance embraces all abnormal sounds (exclusive, of course, of flatness, which is, strictly speaking, absence of sound), which are non-vesicular. It exists in the

most marked degree in cases of pneumo-hydrothorax. But in this affection, if the walls of the chest are distended so as to be made quite tense, the sound may become dull, although in character still tympanitic. The sound transmitted from the stomach or intestines, when percussion is made over solidified lung, is purely tympanitic. The sonorousness sometimes existing over condensed lung, or lung solidified by morbid deposits, at the summit of the chest, is also more or less tympanitic. A tympanitic resonance may also be developed by percussion over tuberculous excavations. In the latter case it is circumscribed in extent. Tympanitic resonance, under these circumstances, occasionally presents a ringing metallic intonation, and it is then called *amphoric resonance*. This modification is sometimes observed when sonorousness exists over solidified lung. Another modification is a *cracked-metal sound* (*bruit de pot fêlé*), sometimes produced by percussing over a cavity of considerable size, superficially situated, having rigid walls, and communicating freely by several orifices with the bronchial tubes. The same peculiar sound, however, has been, repeatedly observed in children at the summit of the chest, being caused by the forcible expulsion of the air from the bronchial tubes."

The chapter on Auscultation contains full directions for the examination of the chest, and a careful and accurate description of the different sounds that may be heard: first, in a healthy chest; and, secondly, in one affected by disease. The different sounds are carefully analyzed and traced to their physical causes. We observe a change in the nomenclature, so far as the term *rude* respiration is concerned—the author substitutes the term *bronch-vesicular* as indicating both the character and source of the sounds. It is described as follows:—

"*Inspiration* presenting vesicular and tabular qualities mixed; shortened in duration; pitch raised; intensity variable; sometimes alone present. *Expiration* oftener present; frequently existing alone; prolonged; occurring after an interval; pitch higher than that of inspiration, and oftener more intense."

The chapter on the condition of the Physical Signs is so important, that we quote the greater part of it, premising that a careful study of the previous chapters is requisite in order to fully understand it:—

#### SIGNS CORRELATIVE TO THOSE FURNISHED BY PERCUSSION,

"1. *Exaggerated Viscular Resonance*.—Occuring in con-

sequence of the activity of the lung on one side being supplementarily increased, the correlative sign pertaining to auscultation is an exaggerated vesicular murmur. Under such circumstances, however, these signs are not intrinsically morbid. They are physiological phenomena exaggerated, but not to a point to be in themselves pathological, and they denote intra-thoracic disease, not at the portion of the chest corresponding to the situation where they are observed, but, inferentially, at another part, and generally on the opposite side. A correlative sign obtained by inspection and mensuration is increased extent of the respiratory movements. The pathological relation of exaggerated resonance to emphysema is more direct and important. The morbid condition in this affection consists in an abnormal accumulation of air, generally within the pulmonary cells, in some rare instances in the interlobular and sub-serous areolar tissue. The correlative sign derived from auscultation is directly the reverse of that in the previous instance, viz., diminution of the respiratory murmur, amounting sometimes to suppression. This combination is highly significant. Other auscultatory signs are frequently associated, but they are incident, not purely to the emphysema, but to coexisting affections, especially bronchitis. This remark applies to the bronchial rales so often present in cases of emphysema. Associated signs, determined by inspection are thoracic enlargement, general or local, corresponding to the extent of the emphysematous dilatation; diminished respiratory movements; obliteration of intercostal depressions; diminished obliquity of the upper ribs, divergence of the lower, and convergence of the upper ribs; if the emphysema be general. The relation of exaggerated resonance to emphysema is the rule; but occasional exceptions are present in cases of great tension of the thoracic walls from the pressure of an over distended lung. In these exceptional instances the resonance may be diminished in place of being exaggerated. The viscular quality of resonance in cases of emphysema is rarely if ever lost, but it is more or less diminished. It is vesiculo-tympanic. In proportion as the intensity of resonance is diminished by tension, the vesicular quality is impaired, and the tympanic predominates.

"Exaggerated percussion-resonance incident to the temporary emphysematous condition which sometimes obtains in bronchitis, pulmonary catarrh, and bronchial spasm, involves, as correlative signs, the adventitious sounds which pertain to these affections, viz., the dry and moist bronchial rales.

"2. *Diminished Vesicular Resonance.*—In the exceptional instances of emphysema in which this modification of percussion-resonance occurs, the correlative signs will, of course, be the



same which, in the majority of instances of that affection, are combined with exaggerated resonance.

"Commonly the affections to which diminution of resonance is incident are those involving either liquid pleural effusion, viz., pleurisy and hydrothorax; or increased density of lung from deposit of liquid or solid matter, viz., pneumonitis, tuberculosis, oedema, pulmonary apoplexy, carcinoma, etc. The correlative signs in these two classes of affections are far from identical; nor are they uniform in the different affections included in the same class.

"In pleuritic effusion sufficient to diminish but not abolish the vesicular resonance, correlative auscultatory signs are, diminished respiratory murmur, and in some instances ægophony. Correlative signs determined by palpitation are, diminished or suppressed vocal vibration, and increased force of resistance to pressure.

"In solidification from pneumonitis and tuberculosis, the correlative auscultatory phenomena, in the majority of instances, are more or less of the characters of the broncho-vesicular, or of the bronchial respiration, together with exaggerated vocal resonance, or bronchophony, and increased vocal fremitus. Exceptional instances are not very infrequent in which, instead of these signs being associated, the respiratory sound is abolished and the vocal resonance and fremitus not increased. The latter constitute the rule, rather than the exception, in the other affections involving abnormal density of lung, viz., oedema, pulmonary apoplexy, carcinoma, etc.

"A correlative sign in cases of oedema, and, less constantly, in cases of pulmonary apoplexy, is the sub-crepitant rale. The crepitant rale is generally associated with diminished percussion-resonance in pneumonitis, but the converse does not hold good to the same extent; in other words, the crepitant rale often appears before the percussion-resonance is sensibly diminished.

"Diminished respiratory movements may be combined in all the affections named, but oftener in pneumonitis and tuberculosis. Increased force of resistance on pressure, and diminished elasticity, is a correlative sign common to all the varieties of solidification.

"3. *Absence of Resonance.*—The anatomical conditions giving rise to diminished resonance may be sufficient to abolish it, rendering the percussion-sound flat, Absolute flatness being in the great majority of instances due to the presence of a considerable quantity of liquid in the pleural cavity, the correlative auscultatory signs are absence of respiratory sound, and of vocal resonance, with notably diminished elasticity of the

thoracic walls. This combination of signs is highly diagnostic; yet the rule is not without exceptions, diffused bronchial respiration being associated with flatness in some cases of large effusion. Absence of vocal fremitus is another correlative sign. If the amount of effused liquid be great, inspection and mensuration furnish important associated signs, viz., enlargement of the chest; obliteration of the hollows between the ribs; divergence of the lower and convergence of the upper ribs; comparative immobility; elevation of the shoulder; widening of distance between the nipple and the median line; depression of the liver, and removal of the heart from its normal position. Fluctuation is occasionally appreciable. This collection of signs incident to enlargement of the chest, may, however, to a considerable extent, be reversed, in combination with flatness on percussion over the greater part of the chest. Absorption of the liquid effusion, inducing contraction, may take place, but not sufficiently to permit a return of percussion-resonance, with reappearance of respiratory sound, vocal resonance, and fremitus. Then, in connection with diminished size of the affected side, there will be convergence of the lower ribs, and divergence of the upper; depression of the shoulder, and narrowing of the distance between the nipple and the median line. Obliteration of the intercostal hollows and comparative immobility will be likely to continue.

"Flatness on percussion may accompany abundant tuberculous deposit, the second stage of pneumonitis, and other affections involving abnormal density of the pulmonary substance. The facts pertaining to correlative signs, which have been stated under the head of diminished resonance, or dullness, incident to pulmonary solidification, will be equally applicable, and need not be repeated.

"4. *Tympanitic Resonance*.—The signs associated with the different varieties of tympanitic resonance differ widely, according to the diversity of anatomical conditions represented. In the affection which presents more than any other a resonance purely tympanitic, strongly marked and diffused, viz., pneumo-hydrothorax, the correlative phenomena derived from auscultation are, the characteristic vocal, tussive, and respiratory sign, metallic tinkling; feebleness or extinction of the vesicular murmur; blowing and amphoric respiration, occasional and irregular; absence of vocal resonance. Inspection and mensuration furnish the group of appearances incident to enlargement from liquid effusion. Palpitation discloses absence or marked diminution of the normal vocal fremitus. Succussion develops the sign incident almost exclusively to this affection, viz., splashing.

"Tympanitic resonance, circumscribed in extent at the summit of the chest, sometimes metallic or amphoric, and occasionally presenting a cracked-metal modification—these circumstances denoting its connection with a spacious pulmonary cavity, superficially situated, with rigid walls and free from liquid contents—exists in combination with cavernous respiration, presenting sometimes an amphoric intonation, alternating with gurgling; occasionally splashing, with the act of coughing, and metallic tinkling; pectoriloquy in some instances; local depression or flattening at the summit of the chest, and deficient expansibility.

"Occurring, as an exception to the general rule, over lung solidified by inflammatory exudation, it is combined, of course, with the various phenomena incident to that anatomical condition.

"When presented in pleurisy, situated above the level of the liquid effusion, and also over the healthy lung in cases of pneumonitis, it cannot be said to have any definite correlative signs, irrespective of those which pertain to the diseases of which it is an incidental feature.

"SIGNS CORRELATIVE TO SOUNDS FURNISHED BY AUSCULTATION.

"1. *Increased Intensity of Vesicular Murmur.*—Proceeding always from hyper-activity of respiration induced supplementarily in a portion of the pulmonary apparatus, the correlative signs are exaggerated percussion-resonance, and increased respiratory movements. The remarks made under the head of Exaggerated Vesicular Resonance are here equally applicable.

"2. *Diminished Intensity of Vesicular Murmur.*—The phenomena associated with this sign are quite opposite in their character, corresponding to differences in morbid conditions which present a contrast equally striking.

"Abnormal feebleness of the vesicular murmur may be due to the removal of the lung at a certain distance from the thoracic wall. This removal is caused by the presence, in some cases, of air or gas; in others, by a stratum of liquid or solid matter, and sometimes by air and liquid together, in the pleural cavity. In the first instance, a correlative percussion-sign is tympanitic resonance; in the second instance, it is absence of resonance, or flatness; and in the third instance, both are conjoined, *i. e.*, tympanitic resonance exists above the level of the liquid, and flatness below this level. The presence of air and liquid, constituting pneumo-hydrothorax, is, however, very rarely characterized by simple feebleness of the respiratory sound; either the latter is abolished, or presents the cavernous

or amphoric modification. Correlative signs incident to this affection are metallic tinkling and a succussion-sound. Diminution of the respiratory motions, of vocal resonance, and fremitus, are common to the morbid conditions just mentioned.

"Again, feebleness of respiration, without change in quality or rhythm, occurs in a certain proportion of cases of solidification from tubercle, inflammatory exudation, œdema, etc. On the other hand, it is incident to emphysema, bronchitis, and partial obstruction at any point in the air-passages. In these two classes of morbid conditions the correlative percussion-signs are precisely reversed. In the first class it is combined with diminished resonance, or dulness; in the second, the clearness of the percussion-sound is either undiminished or exaggerated. The anatomical condition in both instances is marked by the combination. Exclusive of the cases in which the lung is removed by liquid or solid matter, air, or gas, from the thoracic wall, feebleness of the respiratory murmur, combined with dulness on percussion, as the rule, denotes increased density of the pulmonary organ; combined with normal resonance, it indicates that the density is neither increased nor diminished; combined with exaggerated resonance, it is evidence of the abnormal rarefaction of the lung, pertaining to emphysema and some cases of bronchitis. Other signs existing in combination serve to establish the distinction as respects the anatomical condition. In cases of solidification, in which the effect on the respiratory sound is simply to diminish its intensity, the vocal resonance may be exaggerated, and even bronchophony may be present. In cases of rarefaction, this occurs only as rare exceptions to the general rule. The same remark will apply to vocal fremitus. Diminished respiratory motions may accompany both anatomical conditions. Enlargement of the chest, and its attendant phenomena, determined by inspection, mensuration, and palpitation, pertain to emphysema. Diminished elasticity of the thoracic walls belongs to the former anatomical condition (increased density); increased elasticity to the latter (rarefaction).

"3. *Suppressed Respiration.* — Abolition of the sound of respiration, occurring in connection with the same diversity of morbid conditions as diminished intensity of the respiratory murmur, presents similar combinations with other signs.

"Accumulation of liquid or gas, or both air and liquid, within the pleural sac, in sufficient quantity to render respiration inaudible, gives rise, in the first instance, to flatness on percussion; in the second instance, to tympanitic resonance; and in the third instance, to tympanitic resonance above and

flatness below the level of the liquid. Diminished respiratory movements, together with absence of vocal resonance and fremitus, are common to the three morbid conditions, and, in addition, first in the order of time, are presented the phenomena attending enlargement of the chest, which need not be again enumerated; and, second, the reversed phenomena following absorption of the fluid, sufficient to induce contraction, but not to permit re-appearance of the respiratory sound.

"In the cases of solidification from tubercle, inflammation, œdema, etc., in which suppression occurs, it is combined with notable dullness on percussion, as the rule, and with a clear tympanitic resonance, as an exception to the rule. Exaggerated vocal resonance, or bronchophony, and increased vocal fremitus, may exist in combination, together with diminished respiratory movements. On the contrary, in the cases of emphysema, in which the respiratory sound is lost, exaggerated percussion-resonance, with more or less of the tympanitic quality (vesiculo-tympanitic resonance), is the associated sign as the rule, dullness being observed as an exception to the rule, in some instances in which the tension of the thoracic wall, from distension, is very great. In the former anatomical condition (solidification), the elasticity of the parietes of the chest is notably diminished; in the latter (rarefaction), the elasticity is increased. In connection with the suppressed respiratory sound incident to emphysema, the vocal resonance and fremitus are not exaggerated, save in some rare exceptional instances, the reverse being true, as already mentioned, of solidification.

"4. *Bronchial Respiration.*—The bronchial respiration represents solidification of lung, except when it occurs in connection with dilated bronchial tubes, increased density of the pulmonary parenchyma, in the latter case being superadded. The correlative signs, therefore, are those which have direct relation to pulmonary solidification, as it exists more especially in tuberculosis and pneumonitis, the bronchial respiration being much oftener present and more strongly marked in these than in other affections in which the density of the lung is increased, viz., œdema, extravasation of blood, etc. The group of signs has been already given in connection with diminished vesicular percussion-resonance, and diminished or suppressed vesicular murmur, when these signs are due to the same anatomical condition, *i. e.*, solidification. The associated signs, when the bronchial respiration exists, are much more uniform than those presented in combination with dullness or flatness on percussion, or with suppressed or diminished respiration, owing to the fact that the anatomical condition represented, in the vast majority

of instances, by the bronchial respiration is the same, while the signs last mentioned are incident to anatomical conditions different, and indeed opposite, in their character. Dulness on percussion, exaggerated vocal resonance, or bronchophony, increased vocal fremitus, diminished respiratory movements, increased force of resistance to pressure, are the signs sustaining a correlative relation to the bronchial respiration.\*

"5. *Broncho-Vesicular Respiration*. — Representing slight or moderate increase of the density of lung; the correlative relations of this modification of the respiratory sound are essentially similar to those belonging to the bronchial respiration. The difference is, the signs which may be associated are less frequently present, and, when present, are less marked. Dulness on percussion is comparatively slight, and may not be appreciable; the vocal resonance and fremitus may not be obvious, and, if apparent, are weak; the respiratory movements are, perhaps, not sensibly diminished, or, if so, in a small degree; and impairment of the elasticity of the thoracic walls is either not determinable, or feeble.

"6. *Cavernous and Amphoric Respiration*. — Correlative cavernous signs form a group, each preserving always its significance, and not occurring in connection with other anatomical conditions. Actually, however, they are rarely combined, and, indeed, it is impossible for all of them to be present simultaneously, since some can only be produced when the cavity is empty, and others only when it is more or less filled with liquid. The correlative signs requiring an empty space, are the cavernous respiration, pectoriloquy, and circumscribed tympanitic percussion-resonance, inclusive of the metallic modification, and the cracked-metal sound. The correlative signs requiring the presence of liquid, are, circumscribed dulness on percussion, gurgling, splashing with the act of coughing, and occasionally metallic tinkling. The two series of signs may occur in alternation. Both are incident to pulmonary cavities, tuberculous or otherwise, inclusive of pouch-like dilatation of the bronchial tubes; and, also, in the pleural space, in connection with perforation, or, in other words, in pneumo-hydrothorax.

"In the latter affection, the cavernous respiration oftener pre-

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\* \* Under the head of Correlation of Physical Signs, I design to embrace only those which sustain toward each other direct relations. The signs incident to pleuritic effusion in the instances in which bronchial respiration exists over the compressed lung, are indirectly related, and, therefore, not included among those to which the term correlative is applied. For the same reason, I do not enumerate among correlative signs those supplementarily induced by various affections in parts of the lungs more or less remote from the situation of the disease.



sents the amphoric character; and the associated signs differ from those pertaining to pulmonary cavities. The percussion-resonance is more constantly tympanitic, is not circumscribed, but more or less diffused. Liquid, in greater or less quantity, is always present, and hence flatness co-exists with tympanitic resonance, the former situated above, and the latter below the level of the liquid. Metallic tinkling is generally observed, while in pulmonary cavities it is of rare occurrence. The succussion-sound is common, which is exceedingly infrequent in cavities formed within the lungs. The phenomena attendant on enlargement of the chest, are generally present in cases of pneumo-hydrothorax, and absent in intra-pulmonary excavations.

"7. *Adventitious Respiratory Sounds, or Rales.*—The adventitious sounds, or rales, may be considered under one heading, for, excepting a single species, viz., gurgling, they resemble each other in not sustaining toward other signs any fixed correlative relations. In this respect, they offer a striking contrast to the signs already enumerated. The moist and dry bronchial rales, including the sub-crepitant, generally represent pulmonary catarrh or bronchitis. They constitute all the positive or direct physical signs belonging to these affections. Other signs, it is true, are frequently found associated with them, but in such instances, pulmonary catarrh or bronchitis are superadded to other affections. The connection is one of coincidence, not of a pathological relation. This deficiency of correlative signs has a positive and important bearing on diagnosis. The presence of the bronchial rales, taken in connection with the absence of abnormal percussion-sound, or other signs, establishes the existence of the diseases which they represent, disconnected from other affections. The crepitant rale represents, in the great majority of the instances in which it is observed, pneumonitis. Pneumonitis during its career presents, as has been seen, a group of correlative signs; but the crepitant rale, strictly speaking, cannot be considered to stand in a correlative relation to any of them, for it is developed often prior to their appearance, and although it very frequently persists after other signs have appeared, this is by no means uniformly the case. Moreover, in a certain proportion of cases, it does not appear during the course of the affection. In the instance of this disease, as of bronchitis, the absence of co-existing signs is an important point, for, in connection with certain symptoms, it may denote the existence of pneumonitis, not advanced sufficiently to give rise to the pathological changes represented by associated signs. This point may have a materia

influence on the therapeutical management of the disease. The indeterminate rales, although often combined with other physical phenomena, and deriving much of their diagnostic significance from the combination, have, nevertheless, no fixed or definite correlative signs. In other words, there are no signs involving the co-existence, even in a considerable proportion of instances only, of the indeterminate rales.

"8. *Friction Sounds*.—These resemble the foregoing rales in not sustaining definite correlative relations to other signs. They differ, however, in this respect, viz., clinically, they are very rarely found isolated; they are associated with signs to which they do not stand in a fixed or uniform relation. The associated signs are different, according to the different circumstances under which the friction-sounds are developed. Representing, in the great majority of instances, pleuritis, they may or may not be associated with the physical evidences of a certain amount of liquid effusion. Occurring either at the commencement or at a late period in the career of the disease, they may or may not be accompanied by the phenomena pertaining to contraction of the chest. Being incident not only to simple pleurisy, but occasionally to pleurisy developed as a complication of tuberculosis and pneumonitis, they may be found in combination with the groups of the physical signs representing the latter affections."

This chapter closes Part I. Part II., treating of "Diagnosis of Diseases affecting the Respiratory Organs," is equal or superior in interest to the previous part of the work, but we have no space for further comments or extracts. The analytical method has been pursued so far as practicable. We unhesitatingly commend the book to all who wish to become well acquainted with thoracic diseases, and the signs by which they may be distinguished.

J.

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*A Practical Treatise on the Diseases of the Testis and of the Spermatic Cord and Scrotum, with numerous wood engravings.* BY F. B. CURLING, F.R.S., Surgeon to the London Hospital, &c., &c. Second American from the second revised and enlarged English Edition. Philadelphia, Blanchard & Lea, 1856.

It is unnecessary for us to say anything in favor of this truly excellent work of Mr. Curling's. The American profession are already acquainted with its merits, and the simple announce-

ment of a new edition is sufficient to secure for it that attention which its merits deserve.

For sale by KEEN & LEE.

J.

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*Human Physiology.* By ROBLEY DUNGLISON, M.D., L.L.D. &c., &c., &c., with five hundred and thirty-two Illustrations. Eighth Edition, Revised, Modified, and Enlarged, in two Volumes. Philadelphia, Blanchard & Lea, 1856.

We cannot attempt a review or analysis of this work. It constitutes a kind of Encyclopedia of Physiology, in which the doctrines and opinions of the present age, are mingled with those of the past. Dr. DUNGLISON, as our readers are aware, is distinguished for his great learning, rather than for originality of investigation. It is for this reason that his compilations are more valuable than his original works. We say this without wishing to detract in the least from the reputation of this distinguished author, whose name has become so intimately associated with the science of Medicine in this country.

The work is for sale by KEEN & LEE.

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## EDITORIAL.

### *The Presidency of the American Medical Association.*

Under this head we find the following as the leading editorial in the September number of the *Buffalo Medical and Surgical Journal*, viz:—

“It is evident that the time has arrived when some change in the manner of selecting the presiding officer of our national congress must be made. We have felt for years that some one should speak out upon the subject. We would have spoken a year ago, had not the fact that the meeting of the association, for 1856, was to be held at Detroit, and that the candidate then most prominent and since successful, had been in a position of personal antagonism with an interest which we represent, prevented us. Any attack made by us, at that time, would have been construed as personal, and as having its origin in local prejudices or jealousies; we therefore held our peace, and consented to forego our protest against an evil which must eventually impair the respectability of the association, and turn from it the regard of the best men in the profession.

"The next meeting is to be held at Nashville. We have none but friends in that locality, and we believe that they, too, will acquiesce in our plans for reform, or help to suggest another looking to the same end.

"The evil to which we allude is self-evident. Custom, not law, has made it the usual course to select the president of the association from the city in which the session is held. Thus the two meetings held at Philadelphia have given us Profs. Chapman and Wood, as presidents; that in St. Louis, Prof. Pope; that in Richmond, Dr. B. R. Wellford; and that in Detroit, Dr. Z. Pitcher. In only one instance has the rule failed to hold good. At the meeting in New York, in 1853, no one worthy of the office was found in that great city, and Dr. Jonathan Knight, of New Haven, was chosen. We hoped then that the precedent thus established in a large city, might be permitted to hold good in the small towns; but it is not so to be. It is evident, that until it is put out of the power of the nominating committee to virtually elect the president, we shall forever be subjected to the rule of that happy individual who happens to be the Nestor of the place of meeting. Grey hairs are honored at the expense of working men. Worse than this. To follow back the chain of promotion, we shall find that the association take the man the nominating committee choose to give them, and the committee take the man they are instructed to by the wire-pullers of the particular locality. In a small town, with from forty to fifty physicians, this matter can usually be cozily arranged among themselves, with more regard to their own interests than to the dignity of the association.

We regard the presidency of the American Medical Association as an honor too high to be lightly bestowed upon any man. The consideration of locality is the last that should be thought of. It is nonsense to make it a mere compliment to a town, in return for a good feed and abundant champagne. The occupant of that high station should be chosen from the profession at large. He who has labored; he who, through many years, has toiled to advance his profession; he who has built up for himself a name as a discoverer or medical philosopher; and who, perhaps, has found no other reward than a good name for all his efforts, such an one is our candidate.

"Under the present system, we can only elect him by accident. Such men as Bartlett, Drake, Morton, Parker, Mott, or Gross, can never be chosen under our present system. Those of them who are dead never would, and those who live never will, do the necessary work.

"The machinery by which presidents are made under the

present constitution, is very simple. A special committee of one from each state is appointed by each delegation, to nominate all the officers. This special committee is a small body of men, and will never have the courage to break down the strong precedent now established. At the last meeting, Dr. Bloodgood, of Ill., offered a resolution, "That the constitution of this association be so amended as that hereafter the president shall be elected by ballot, and shall not be resident of the state in which he is elected."

"On motion of Dr. Watson, of N. Y., this was laid on the table. We do not like the resolution. The best man might be a resident of the state in which the meeting was held, and locality should not exclude him.

"What shall we do? The nominating committee is a bad piece of machinery in some respects, and a very good one in others. We have shown where its faults lie. It only requires a moment's thought to perceive that it must very much facilitate the selection of a place of meeting, and the nomination of committees. Indeed the argument of convenience is so strong, that we would willingly allow it the choice of all the officers except the presidency, reserving that as a distinguished honor to come direct from the association.

"We propose the following amendment to the constitution:—

"*Section IV. Officers.*

"The officers of the Association shall be a President, four Vice-Presidents, two Secretaries, and a Treasurer. *With the exception of the president, they shall be nominated by a special committee of one member from each state represented at the meeting, and shall be elected by vote on a general ticket. The president shall be chosen by ballot of all the members, the first ballot to be informal, and the person receiving the highest number on the second ballot, to be declared elected.*"

"Our amendment consists in the addition of the italicised portions to the present provisions. We throw it out to the profession at this time, in the hope that it may excite discussion in the Journals. We suppose that the motion of Dr. Watson, laying Dr. Bloodgood's resolution on the table, was superfluous; and that it may be properly brought up for discussion and amendment at the next meeting. Dr. B.'s resolution would have been laid on the table under the rule, had Dr. Watson withheld his motion. If we are right in this supposition, our proposition may come up at the Nashville meeting as an amendment to Dr. Bloodgood's.

"If we had any faith in committees, we should move simply to instruct them to be governed by the spirit of the constitution,

which does not circumscribe their choice to any locality; but we have no such faith, and so resort to what seems to be the only practicable plan. As, under the present rule, the president is chosen early in the session, the proposed change can have no effect on next year's choice. We should, however, wish the amendment acted on before the selection of the place of meeting for 1858, for obvious reasons."

With the main sentiment of the above we fully concur. But it contains one or two errors which should be corrected.

It is not true that "in only *one* instance has the rule" of selecting the president from the place where the meeting was held, "failed to hold good." At the first regular anniversary meeting, held in the city of Baltimore, the President elected was Dr. Alexander H. Stevens, of New York. Neither was it true that at the meeting in New York in 1853, "no one was found in that great city *worthy* of the office," as asserted by our friend of the *Buffalo Journal*.

At that meeting in New York, the writer of this was a member of the nominating committee, and took an active part in the matter of selecting a candidate for President of the Association.

There were presented to the committee by the profession of New York, two candidates, namely, Dr. John W. Francis and Dr. Valentine Mott, both eminently *worthy* of being President of any Association. No member of the nominating committee objected to either of these men. Neither would there have been any objection to half a dozen other names that might have been selected from the profession in the "great city of New York." But several members of the committee did object strongly to the precedent, already established, of selecting a candidate necessarily from the place of meeting. Not only did members of the committee object to the propriety of the rule or precedent, but they claimed that then and there was the best possible *time* and *place* for repudiating it altogether. It was the best time, simply because the quicker a bad rule is broken the better. It was the best *place*, because the profession in New York having already furnished one President of the Association at a meeting in another city, would have less reason to complain on that account. The whole matter was fully and freely discussed in the committee, and when it recommended to



the Association the election of Dr. Jonathan Knight, of New Haven, it was not from disrespect to New York or New Yorkers, but solely to repudiate a bad rule founded on precedent alone. We then hoped that subsequent committees would follow the example there set, and were much disappointed to find them refusing to do so at the next meeting held in St. Louis.

We are glad to see that the subject is at last attracting the attention of the profession.

For ourselves, we have heretofore uniformly opposed the practice of making the election of president depend on the accidental circumstance of location, and shall continue to do so, as long as we have any voice in the matter.

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#### *Dysentery.*

Dr. Shoemaker, of Columbia, Monroe County, states, in a recent letter to us, that dysentery has been very prevalent and severe in that locality during the last part of summer and autumn. We have received similar intelligence from several other neighborhood, including places in Michigan, Wisconsin, and Iowa.

In this city, during the months of July and August, many children under two years of age suffered from attacks of this disease; and during the last month (September) cases of typhoid and typhus fevers have been more frequent than usual. Still, the ratio of mortality, from all diseases, during the year, has been low, and the season will be ranked as one of good health. A more full report in regard to the diseases of the past summer and autumn, noting their peculiarities, both pathological and therapeutical, will be published in our next number.

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#### *Rush Medical College.*

The regular annual course of medical instruction in this Institution commences on the first Monday in November. And we believe everything is in readiness for as full and valuable a course of instruction, in all the departments, as is to be found in any of the schools in our country. The hospitals are well-filled with patients, furnishing more material for clinical instruction than can be conveniently used; while the *material* and

means of illustration in practical anatomy, surgery, &c. are limited only by the wants of the Faculty and the Class. Students have already begun to arrive (Oct. 3) for the purpose of attending to dissecting and clinical instruction one month before the regular term commences. The prospects are favorable for a full class.

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*To Subscribers.*

The mailing of the September number of the *Journal* was delayed two weeks for the purpose of enclosing bills to subscribers.

There is over \$1,800 due us on Volumes IV. and V. of the *Journal*. Two or four dollars is but a small sum, which would hardly be missed by any individual subscriber; but \$1,800 is a large item for us to wait for.

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*Rush Medical College.*

Since the annual announcement of this Institution for 1856-'7 was printed, the following changes have been made, in consequence of Dr. E. Andrews declining longer to continue in the position of Lecturer on Comparative Anatomy and Demonstrator. Dr. J. H. Hollister, of this city, has been appointed Demonstrator of Anatomy, and Dr. J. C. Morfit, Prosector to the Chair of Surgery. Both these gentlemen are well known and highly esteemed, and are eminently qualified for the respective stations to which they have been appointed.

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MISCELLANEOUS ITEMS.

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*Mortality in the French Army in the East during the Late War.*

It has been our lot, on many occasions, to show that the chances of war are far less fatal to the soldier than the diseases he encounters when on foreign service. The sanitary history of the French Army of the East, during the late campaign in the Crimea, is full of facts which confirm the truth of this

proposition in a manner so frightful and astounding that we have long doubted the accuracy of the accounts which have reached us from week to week; and it is only by the accumulated testimony of eye-witnesses, and the reports of medical officers high in the French service, that we have been able to admit the possibility of a rate of mortality among our allies so unprecedented as almost to exceed belief. For the truth of the following statements, however, we have the authority of medical officers both in our own and the French service, and have permission to name them if need be. They are not only interesting in themselves, but additionally so, as the facts have been studiously concealed by the French Government, and are now made known for the first time in this country:—

1. There were fourteen French hospitals in the Bosphorus up to the end of March. Since then three others have been added. The following is a copy of an official return of the patients treated in all the hospitals in January, February, and March, 1856:—

January,	- - - - -	13,520
February,	- - - - -	21,309
March,	- - - - -	28,167

2. During the ten days ending on the 20th of March, 1,009 *patients died*; and during the following ten days, 948 *patients died*, in these hospitals. The number of sick under treatment for all diseases on the 20th of March, was 11,366, and on the 30th, 9,763.

3. The aggregate loss by death from sickness (nine-tenths being from typhus) in the French hospitals on the Bosphorus exceeded 10,000 during the first quarter of the present year. The daily mortality in twelve of these hospitals in January and February, ranged up to 240.

4. From the 1st of January to the 17th of March, when the transport of typhus cases from the Crimea was discontinued authoritatively, more than 5,000 deaths occurred on board French transports and men-of-war, between the Crimea and the Bosphorus.

5. In the Crimea there were fourteen Field Hospitals, or *Ambulances*, during the same period, each containing from 800 to 1,100 sick. The deaths in each varied from 15 to 20 daily. Thus the aggregate loss by death from disease in these hospitals during this period exceeded 19,000, and is believed to have been very little under 25,000.

6. It is *known* that more than *thirty-four thousand* French soldiers of the Army of the East died from disease during the months of January, February, and March, 1856. It is *believed*

by those able to judge, that those deaths exceeded *forty thousand*.

7. Sixty-four French Surgeons have died in the Crimea and on the Bosphorus since last November. Of 362 Surgeons of all ranks who have served with the French Army since its landing in Gallipoli in the autumn of 1854 to April, 1856, 72 have fallen victims to typhus alone.

8. On the 15th of March, 1856, there were, in the Officers' Hospital at Constantinople, 31 Surgeons in different stages of typhus, and only one combatant officer.

9. Of 840 hospital orderlies and attendants, employed in the sixty days of January and February, 603 were attacked by typhus when on service.—*Med. Times and Gaz.*, June 17, 1856.

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*Cholera in Portugal and Madeira.*—Lisbon letters speak of Cholera as still continuing its ravages in Lisbon and through the provinces. Peniche is now declared infected. The French screw liner, Prince Jerome, has lost several men from this disease and typhus fever. The intelligence from Madeira is very disastrous. Cholera broke out at sea among some Portuguese troops that left Lisbon on the 20th of June, and when they landed at Funchal a fair was being held, the troops mixed with the inhabitants, and cholera broke out among the latter. When the Avon left Madeira on the 3d of August, there had been 5,000 cases of cholera and 1,500 deaths among the population of Funchal, which numbered only 28,000. The panic at Funchal was terrible; all business was suspended, the shops were closed, and every family isolated itself. The dead lay unburied in the cemetery, and fires were kindled there to mitigate the evil effects arising from the putrefaction of dead bodies. The government at length got twelve men to dig graves, and six of them literally dug their own, for they died almost immediately, and were buried in the graves they had made for others. Only one Englishman, an hotel keeper, had died of it. Seventy English escaped from Madeira in the Avon, and these were all the packet could accommodate. There were about two or three hundred left; but, fortunately, this is not the season for English people to be at Madeira.—*Med. Times and Gaz.*, Aug. 16, 1856.

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*Cure of Itch in Half an Hour.*

Dr. E. Smith, at a meeting of the London Medical Society, called attention to an article in the *Gazette Hebdomadaire*, by Dr. Bourguignon, in which is a confirmation of the value of the

treatment of itch, in Belgium, by sulphur, combined with lime, in a liquid form. The remedy is prepared by boiling one part of quick lime with two parts of sublimed sulphur, in ten parts of water, until the two former are perfectly united. During the boiling it must be constantly stirred with a piece of wood, and, when the sulphur and lime have combined, the fluid is to be decanted and kept in a well-stoppered bottle. A pint of the liquid is sufficient for the cure of several cases. It is sufficient to wash the body well with warm water, and then to rub the liquid into the skin for half an hour. As the fluid evaporates, a layer of sulphur is left upon the skin. During the half hour the acarus is killed, and the patient is cured. It is only needful then to wash the body well, and to use clean clothes. In Belgium, the treatment is introduced by first rubbing the body for half an hour with black soap; but this does not appear to be necessary. The only essential act is that of the careful application of the fluid sulphur. The lime is of no importance in the treatment, except to render the sulphur soluble, and such would probably be the case if potass or soda were employed. The chief point in the plan thus employed, which is an improvement upon the mode of application of sulphur in substance with lard, is the more ready absorption of the remedy, and consequently the more certain and quick destruction of the insect, by using sulphur in a fluid form. In so disgusting a disease it must be of great moment to be able to cure it in half an hour.—*Assoc. Med. Jour.*

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*Alsidium Blodgettii* in Consumption and Scrofulous Diseases.

EDITOR NEW YORK MEDICAL TIMES:—

Dear Sir—I wish to direct the attention of the Medical profession to a marine plant, discovered by Dr. A. E. Rue, on the coast of Australia. Dr. R. is very confident that he has discovered some very valuable medicinal properties in this plant, and states, in the most positive terms, that it is a specific in consumption and scrofulous diseases.

I have every confidence in Dr. Rue as not being disposed to speculate on the *Materia Medica*, or attract attention by new and fashionable therapeutic agents; and through his kindness I have been furnished at different times with the medicine as prepared and used by him, and also a specimen of the plant. Upon examination, I find the same plant was originally discovered by Dr. Blodgett, and is accurately and minutely described and classified by Prof. Wm. H. Harvey, of Dublin University, in his classification of *Algæ*. The following is his description of it:—“*Alsidium Blodgettii*—frond sub-compressed below,

terete above, decompound pinnate; pinnæ alternate, patent, close, virgate, the lowest very long, set with short setaceous, spinous-toothed, alternate, distichous ramuli; upper branches short and sub-simple; conceptacle pedicellate, inflated, urceolate, variously placed on the ramuli."

I have used this medicine with the most gratifying results in many cases in my own practice where there was every sign of *tubercular deposition*, some of which were in quite an advanced stage; yet, not satisfied with my own experience, I placed it in the hands of a few medical friends, who were equally well pleased with its success in these diseases. From what I consider the duty of every medical man, I have decided to make these facts known to the profession, hoping that any additional facts pertaining to the history or medicinal properties of the plant will be reported.

Yours, etc.,

BENJAMIN PALMER, M.D.

PITTSFIELD, MASS., July, 1856.

#### *A new Instrument for indicating the Movement of the Heart.*

Dr. Scott Alison has exhibited an instrument to the Royal Society, which he calls a sphygmoscope, and employs it to indicate the movements of the heart and blood vessels. The construction is simple: a small glass tube, about a foot in length, open at the upper end, and with a graduated ivory scale affixed, terminates below in a hemispherical or trumpet-mouth, bent to a right angle with a tube. This mouth is covered with a water proof membrane, and, being filled with colored water, is to be pressed against the ribs where the movement of the heart is most sensible. At once the water starts up the tube, in which it is seen to rise and fall in every beat; and thus all the movements of the vital organ, whether regular or irregular, may be distinctly viewed and measured by means of the scale. A smaller instrument of the same kind will show the beating of the pulse or of any other blood vessel, however small; and the beats may be compared with those of the heart. They are perceptible even at the end of an India rubber tube two feet in length. Already some new physiological conclusions have been arrived at with regard to the circulation of the blood, and a further insight into vital action is hoped for from the general use of the sphygmoscope among medical practitioners.—*Boston Med. and Surg. Journal.*

#### *Vaccination in relation to Blindness.*

Statistical researches show us that, prior to Jenner's discovery, of 100 cases of blindness, 55 were due to small-pox; and



Dr. Dumont, physician to the Hospice for the Blind, has recently supplied an interesting account of the progressive decrease of that proportion. Among the blind of 60 years of age, he finds this variety of cause in 12 per cent; in adults, it only exists as 8 per cent.; and, in children, only as 5 per cent. We may take as a mean, counting all ages, about 7 per cent., which, as at the commencement of the present century, the proportion was 35 per cent., exhibits a diminution of 28 per cent.—*New York Journal of Medicine.*

*Bromine as a specific in Pseudo-Membraneous Affections.*

M. Ozanam, in a paper presented to the Imperial Academy of Sciences, on the 26th of May, announces that bromine is a specific in the pseudo-membraneous affections. He has treated successfully fourteen cases, two of which were cases of true croup. He employed either bromine or bromide of potassium. The dose was from one to ten grains a day.—*Med. Times and Gazette*, June.

*Cholera in Moscow.*

Cholera is raging fearfully in Moscow, which is said to be the true cause of the postponement of the coronation of the Czar.

## STARLING MEDICAL COLLEGE, COLUMBUS, OHIO.

The TENTH ANNUAL COURSE OF LECTURES in this Institution, will commence on the FIFTEENTH OF OCTOBER, and continue full five months.

### FACULTY.

S. M. SMITH, M.D.,	Professor of Theory and Practice, and Dean.
F. CARTER, M.D., *	Professor of Obstetrics and Diseases of Women and Children.
JOHN DAWSON, M.D.,	Professor of Anatomy and Physiology.
J. W. HAMILTON, M.D.,	Professor of Surgery.
THEO. G. WORMLY, M.D.,	Professor of Chemistry.
S. LOVING, M.D.,	Professor of Mat. Med. and Med. Jurisprudence.
R. N. BARR, M.D.,	Demonstrator of Anatomy.

### TERMS:

Lectures, \$60.	Matriculation, \$3.	Graduation, \$20.
Board, Lodging, &c.,	\$2 50 to \$3 per week.	

By a law, passed at the late session of the Legislature, Students of this Institution are admitted free to the Hospital of the Ohio Penitentiary, thus furnishing one of the best Clinics in the country.

For further information, address

S. M. SMITH, DEAN

## PENNSYLVANIA COLLEGE--MEDICAL DEPARTMENT.

SESSION OF 1856-'57.

The Regular Course of Lectures will commence on MONDAY, OCTOBER 13TH, and will be continued until the 1st of March.

### FACULTY.

DAVID GILBERT, M.D.,	Professor of Obstetrics and Diseases of Women and Children.
ALFRED STILLE, M.D.,	Professor of Theory and Practice of Medicine.
JOHN NEILL, M.D.,	Professor of Surgery.
J. M. ALLEN, M.D.,	Professor of Special and Surgical Anatomy.
JOHN J. REESE, M.D.,	Professor of Medical Chemistry.
JOHN B. BIDDLE, M.D.,	Professor of Therapeutics and Materia Medica.
FRANCIS G. SMITH, M.D.,	Professor of Institutes of Medicine.
H. W. DeSAUSSURE FORD,	Demonstrator of Anatomy.

Clinical Instruction will be given by Professors BIDDLE and NEILL, at the *Philadelphia Hospital, Blockley*, during the entire term of the session, in conjunction with other members of the Medical Board of the Hospital. The Students of Pennsylvania College—both *first-course* and *second-course*—will be furnished *gratuitously* with the Ticket to the Philadelphia Hospital. Second-course Students have the option of receiving *gratuitously* the Ticket to the Pennsylvania Hospital. A Clinic will also be held at the College every Wednesday and Saturday morning throughout the session.

### FEES:

For the entire Course of Lectures,.....	\$105
Matriculation, paid once only,.....	5
Graduation, .....	30

The Dissecting Rooms will be opened in September, under the direction of the Professor of Anatomy and the Demonstrator.

Preliminary Lectures will be delivered during the fortnight preceding the opening of the session.

JOHN J. REESE, M.D., REGISTRAR,  
No. 342 Walnut Street, below Thirteenth, Philadelphia.

## ST. LOUIS MEDICAL COLLEGE.

The Regular Lectures in this Institution will commence on the FIRST DAY of NOVEMBER, 1856, and continue until March. A preliminary Course at the College, as also Clinical Lectures at the Hospitals and the Dispensary, will be delivered without extra charge during the month of October.

M. L. LINTON, M.D.,	Professor of the Principles and Practice of Medicine.
A. LITTON, M.D.,	Professor of Chemistry and Pharmacy.
CHARLES A. POPE, M.D.,	Professor of the Principles and Practice of Surgery and Clinical Surgery.
M. M. Pallen, M.D.,	Professor of Obstetrics and Diseases of Women and Children.
W. M. McPHEETERS, M.D.,	Professor of Materia Medica & Therapeutics.
CHARLES W. STEVENS, M.D.,	Professor of General, Descriptive, and Surgical Anatomy.
JOHN B. JOHNSON, M.D.,	Professor of Clinical Medicine and Pathological Anatomy.
J. H. WATTERS, M.D.,	Professor of Physiology and Medical Jurisprudence.
E. H. GREGORY, M.D.,	Demonstrator of Anatomy.

The most ample opportunities for clinical instruction, both in Medicine and Surgery, are afforded by the several large Hospitals and Dispensary under the care of the Faculty. There is also an abundance of material for the study of practical anatomy.

Fees for the entire Course, \$105. Matriculating Ticket, paid but once, \$5. Dissecting Ticket, \$10. Hospital Tickets, gratuitous. Graduating Fee, \$20.

Students or others desiring further information, can either address the Dean, and he will forward them a descriptive pamphlet, or, on arriving in the city, call upon him at his office, south-west corner of Tenth and Locust Streets, or on the Janitor of the College, corner of Seventh and Myrtle Streets.

July, 1856.

CHARLES A. POPE, M.D., DEAN.